SOCIAL WORK EDUCATION

Bi-Monthly News Publication

COUNCIL ON SOCIAL WORK EDUCATION • 345 EAST 46 ST., NEW YORK 17, N. Y.

Volume I. Number 3 August 1953

THE EVOLUTION OF MEDICAL EDUCATION: Its Implications for Other Professional Disciplines

by

John L. Caughey, M.D.

Associate Dean, School of Medicine, Western Reserve University

EDITOR'S NOTE: This is a summary of the talk made by Dr. Caughey at the dinner meeting of the Council on Social Work Education on June 4th in Cleveland. Although this summary does not contain the wealth of illustrations and the many details related to the process of making changes in the Medical School curriculum at Western Reserve University which the speaker brought out in his talk, it includes such pertinent information for the profession of social work that it is being made available to a wider audience through publication in this issue of SOCIAL WORK EDUCATION.

Medical schools have become large and strong. It is easy to accept them in their present form and to forget the arduous course of their development. Today there is great interest in educational processes, in medicine and other professional disciplines. The problems of medical education, and the efforts being made to solve them, can be understood only through analysis of the dynamic evolution of medical education in modern times, and appreciation of the many factors in our society which have influenced programs for physician training.

In the pioneer period in the 18th and early 19th centuries, physicians were trained largely by apprenticeship to a practitioner of medicine. Although there were a few university-affiliated schools in this period, their academic requirements were minimal and the number of their graduates small in relation to physicians trained by a clinical preceptorship with little or no academic flavor.

Many medical schools were established during the 19th century, but most of them were far different from our present institutions. These schools were "proprietary" schools, owned by the Faculty and operated for the profit obtained from lecture fees, or from the prestige and consultation practice resulting from a professorship. Our own School is a good example. It started in Cleveland in 1843, when the rest of the institution was 30 miles away in Hudson, Ohio. There were 7 professors on the Faculty, each of whom collected fees from students attending his lectures. The chief facility was a lecture room. The M.D. degree was granted on the basis of attendance at 2 series of lectures, each 16 weeks long, and completion of 3 years of apprenticeship under a recognized physician.

The development of our present pattern of medical education came about gradually as a result of several types of pressure. The most fundamental was the emergence of biology, chemistry and physics as scientific disciplines and the belief of physicians, educators and the public that medical practice should be based on a sound scientific foundation.

OFFICERS

HELEN R. WRIGHT, *President* • BENJAMIN E. YOUNGDAHL, *First Vice President* • ERNEST B. HARPER, *Second Vice President*
JANE M. HOEY, *Third Vice President* • EILEEN BLACKEY, *Secretary* • WILBER I. NEWSTETTER, *Treasurer*

STAFF

ERNEST F. WITTE, *Executive Director* • KATHERINE A. KENDALL, *Educational Secretary* • ANN ELIZABETH NEELY, *Secretary to Commissions*

The medical profession recognized the impact of modern science by organizing local and state medical societies to promote better education. In the latter half of the 19th century, the Association of American Medical Colleges was launched to improve educational standards, and the American Medical Association created its Council on Medical Education and Hospitals for the same purpose.

As science came into medicine, the operation of medical schools became difficult for physicians trained only in the clinic, and the profit disappeared as soon as academic standards rose and emphasis was placed on the need for laboratory facilities and hospitals providing well supervised clinical experience for students.

The public concern over standards of medical education was manifested by the establishment of State Boards for the examination of physicians seeking licensure, and the listing of academic prerequisites for admission to such examinations. Thinking citizens were quite properly aroused by the conditions described by Dr. Abraham Flexner in his book, "Medical Education in the United States and Canada", published in 1910, at which time there were more than 150 medical schools in existence in the United States, the majority of them still in the "proprietary" class.

Actually the present pattern of medical education became recognizable only late in the 19th century. Its academic stature was immeasurably increased by the establishment of the Johns Hopkins Medical School in 1893, which required a four-year college program as a prerequisite for admission. The proprietary medical schools virtually disappeared about 40 years ago, but medical schools have not yet reached a truly graduate status, since many of them accept students who have completed only 3 years of college study.

This historical review does more than give comfort to younger professions, such as social work, which have not yet attained all their academic objectives. It helps to clarify some of the defects in our present training programs, and to explain the increasing enthusiasm among medical educators for efforts to improve their teaching methods.

The developmental background explains why there has been a sharp division in medical schools between basic science and clinical medicine. The science was intruded into medicine at a time when most of the clinical teachers were unable to understand or apply the knowledge and methods of science. It was easy then to make the science courses a separate entity, after completion of which the student could move over into the hospital and participate in the care of patients. Now that most clinical teachers are well versed in the methods of science, it seems desirable to breakdown this dichotomy, so that from the first the student can see that the sciences provide tools necessary for study of the problems of sick people.

The history of medical education sheds light on some of the methods of our medical schools. Since medical schools have only gradually approached the status of graduate schools, it has been easy for them to adopt devices, such as lectures and frequent quizzes, which are perhaps appropriate for mass production of high school graduates, but which are of limited value in a program for mature persons preparing for a professional career. This historical review suggests also that our rigid compartmentalization into Departments occurred when we adopted the University as the means for raising the standards of medical education, and accepted its pattern of specific and limited courses. This type of organization undoubtedly was a good antidote for purely empyrical or clinical teaching, but it has not proven to be one which encourages a broad view of medicine on the part of students.

Furthermore, this recent pattern of medical education has lost much of the personalized instruction of the old preceptorship. It places emphasis on the transmission of highly organized information by the teacher to large classes of students, and on the regurgitation of this material by the students on written examinations. There is not much oppor-

tunity in this system to help the student develop a basic philosophy of medicine or a deep sense of responsibility in his professional obligations.

In developing a new program it seemed desirable to break down department barriers in teaching, to encourage broad interest in all aspects of medicine, to help the student develop responsibility for self education, and to assist him in establishing a sound basic philosophy for his professional career.

Working toward these objectives has been costly in faculty time and in money. The steps we have taken have not yet been tested sufficiently for accurate appraisal and time does not permit a detailed discussion of them. We put the program in operation with the entering class in September 1952. In Phase I these students have studied normal structure and function. Their instruction has been in the hands of interdepartmental groups, known as subject committees. The laboratory work has been done in a new "multidiscipline" facility, where each student, with his partner, has a work space which is his for use anytime day or night. Tuesday afternoons and all day Thursdays have been "free time" which the student can use as he sees fit. There have been four anonymous interim examinations, which gave the students and faculty information about the effectiveness of instruction, but diminished the tendency to concentrate on cramming for tests at the expense of broader objectives. Only the 3-day final comprehensive examination goes into the records.

In an effort to keep alive the entering student's interest in health and people, and to give an early orientation toward medicine, it was decided that personal contact with a patient would be desirable for each student. After much discussion it was agreed that each first year student would be assigned to a pregnant woman in the antepartum clinic, to follow her through delivery and back to the home, where he could continue to observe the growth and development of the infant in the family setting. In this program we were greatly assisted by social workers who interviewed and selected the patients, introduced the students to them, and served as consultants throughout the year. In addition, a series of lectures was given on the patient-physician relationship, the family, and child growth and development. Throughout the year, the students in groups of 8 met regularly one or two hours each week with a clinical preceptor who came to know the members of his group well, and helped them evaluate the problems of their families. It was also necessary to organize a special well-baby clinic where pediatricians could have the time to do an excellent type of care and instruction.

It is obvious that with 80 students and 80 families this has been a large project. However, it has gone with remarkable smoothness considering our inexperience and the complex things which can happen to both students and families.

Although no extensive analysis of the total program is justified, there are some details I would like to mention:

1. Because of the decision to do correlated teaching of structure and function,we started with a clean slate. On the basis of logic, it was natural to start instruction at the most basic level, the cell. Here no gross anatomy was necessary. As a result of this, our students were in medical school more than 2 months, and many of them had already been assigned to patients, before they were required to dissect the human body, or to subject themselves to the crushing weight of Gray's "Textbook of Anatomy". It is possible that we have underestimated the effect on students when under the standard curriculum they are put in the dissecting room at the very start of their careers in medicine.

2. There are no textbooks which fit easily into a program of multi-department teaching. Our subject committees have had to compose a very extensive syllabus for both lecture and laboratory exercises. From this the students have had to work back into published materials, principally textbooks, often involving several different disciplines at the

same time. This is perhaps something like what they will have to do in deriving information from various sources about a patient.

3. All students have some anxiety when assigned unfamiliar tasks. The Freshmen were anxious about making first personal contacts with patients, but not much more so than Sophomores or Juniors have been in the past. The students were often concerned about the honesty of their posing as members of the health service team in the existing state of their ignorance. However, most of the students and the families have come to value their relationship in this program. The students have been very eager and effective in finding answers to the questions of their patients.

4. Even first year students are readily susceptible to the idea that there is something exciting about disease, whereas normal health is uninteresting. Much effort is needed to keep them aware of the many problems which a normal family has, and the tremendous value which resides in the prevention of breakdown and symptom formation as a result of these problems.

Even to carry our new curriculum this far has been costly. We are encouraged in our efforts by the hope that some of the things we learn will be helpful to other medical schools and other professions. We also appreciate more than ever the need we have for help in resolving some basic educational problems, which social work education and other professions face, too.

1. To guide professional education, we must have some definition of the quality of professional services. It is not adequate to assume that those who have met stated educational requirements forever after render excellent service, while all others provide a less good service. Unless we know how to define good professional service, it is very difficult to define our educational objectives, to design a proper curriculum, to improve instructional methods, or even to evaluate educational experiments such as ours. Certainly medicine has no good criteria at present which it is feasible to use to evaluate the quality of medical care.

2. Under the pressure of increasing factual knowledge, large classes, and special demands on teacher's time (such as administration and research), many graduate school programs have adopted didactic mass production methods, which encourage rote memory on the part of the student, with the mastery of some simple techniques. An impartial analyst would probably define some medical school, and other professional school efforts as training rather than education, since they involve no real development of the students' initiative, responsibility and wisdom. All professional educators share the dilemma of how to provide each student with the necessary factual basis for a professional career without stifling his enthusiasm for doing intelligent thinking for himself. We pay lip service to the importance of self-discipline and self-education but do little to encourage the student to get satisfaction from setting high standards of performance for himself, and working hard to live up to them. There is some tendency now to treat "the patient as a whole", but we have not yet mastered the technique of educating "the student as a whole".

3. Professional schools have three functions, education, research and service. In many fields the first two cannot be carried out effectively unless the school either directly or through a close affiliation agreement controls a service program. However, if a service function is to be used for teaching, it must be carried on in an exemplary manner. This means limitation in volume of service and high cost per patient or client. We all face many difficulties in trying to bring proper balance between teaching and research, and our service obligations. It is not easy to be sure that all services we render or supervise will be setting a good example for future professional practice. We believe that high quality professional service is a community asset, but we have done little to convince our communities that they should pay for such services to clients and make

possible the facilities and personnel required if high quality services are to be rendered to all who need them.

4. All professional education is now deeply involved in problems of specialization. We face the obligation to produce graduates who as practitioners can meet the needs of the community. We know that in many communities it is not feasible to have a high degree of specialization among the members of the health and welfare team. On the other hand our teaching and research appear to require more and more narrow specialists. In medicine this is closely related to the functioning of our teaching hospitals, where the specialization is far advanced, and where the student gets a poor perspective of the role of the physician in relation to the other members of the health service team. Specialization and institutionalization go hand in hand. They are of great value in professional education. However, practice of a profession for the benefit of an individual in his normal setting requires a variety of skills. Under most circumstances it is not economical, feasible or desirable to have each client deal with a large group of specialists to get what he needs. Professional education has the responsibility therefore to reconcile the need for broadly skilled practitioners with the desirable aspects of specialization in teaching and research.

Although our new teaching program has been in effect only one year, it was preceded by several years of intensive study and discussion. From these, and the experience of the past year, there are some conclusions of general application:

1. Graduate professional students have a great capacity for growth if they are given an opportunity to develop initiative and self discipline in a stimulating environment. Continuity of relationship with individual instructors, individual patients, and projects of their own selection seems to help them develop mature attitudes.

2. The greatest stimulus to students is a faculty interested in basic problems of education and willing to work toward their solution. Curriculum revision of a major sort is a project for the faculty which brings instructors from all departments together. This can be of great benefit to the instructors themselves and to the climate of the school. Teachers have much the same problem as parents, and often find it difficult to allow their charges a free rein. This educational "momism" is out of place in graduate professional schools, but it is difficult to dislodge since many teachers have considerable anxiety about their responsibilities to students.

3. Schools which train professional personnel for the health team, have great responsibilities which they can never fully meet. Without hope of complete success, they must attempt to appraise the quality of service presently rendered by the profession, estimate the future needs of the community both qualitatively and quantitatively, and adjust their education programs to new objectives resulting from these studies. At the same time they must advance knowledge and technique through vigorous research.

4. A review of the evolution of medical education emphasizes the dynamic nature of the relation between community needs and educational processes. Progress has often been distressingly slow, even in medicine where the connection between the schools and the community health has been readily understood by the public. It is obvious that in other professions, younger or less favored in respect to public interest and financial support, considerable time will be required before even presently visualized goals can be reached. However, there has been encouraging acceptance of the concept of team work in provision of health services. The increasing complexity of medical and welfare programs, and the role of the social worker in bringing these services to clients under conditions which promote personal dignity and constructive effort, cannot fail to be appreciated by other professions and the public. In its brief career, social work education has accomplished much. The future presents many unsolved problems, but also a magnificent opportunity.

ANNOUNCEMENTS

The 1954-55 Fulbright opportunities for university teaching and advanced research have been released. There are social work opportunities in Egypt, Germany, Italy, Netherlands, Norway, United Kingdom and United Kingdom Colonies. For detailed information write the Conference Board of Associated Research Councils, 2101 Constitution Avenue, Washington 25, D. C.

New York University has announced the appointment of Benjamin Lyndon Ph.D. as Educational Director of the Social Service Division of its Graduate School of Public Administration and Social Service.

The University of Toronto has established "The Cassidy Memorial Senior Fellowships in Social Welfare Research" for the academic years 1953-54 and 1954-55. Detailed information on these fellowships can be obtained by writing Charles E. Hendry, Director, School of Social Work, University of Toronto, Toronto, Canada.

A "Conference on Undergraduate Education for Social Work" was held at the Kellogg Center, East Lansing, Michigan on May 1-2, 1953. Copies of the very informative report may be had by writing the Department of Social Work, Michigan State College, East Lansing, Michigan.

The Council announces publication of:

1. Its new MANUAL ON ACCREDITING STANDARDS FOR GRADUATE PROFESSIONAL SCHOOLS OF SOCIAL WORK. Price of the manual is $10. This includes the cost of keeping the manual current.

2. A new case record book entitled SOCIO-CULTURAL ELEMENTS IN CASE WORK containing 7 teaching records on Italian Americans, Puerto Ricans, Czechs, and Orthodox Jews. It was prepared by the New York Cultural Project, a working committee associated with the Council on Social Work Education and sells for $1.25 per book or $1 per book if purchased in quantities of 10 or more. Available second week in September.

3. The following articles are available:

   A CONCEPTUAL FRAMEWORK FOR THE SOCIAL WORK CURRICULUM OF TOMORROW by Katherine A. Kendall, reprinted from THE SOCIAL SERVICE REVIEW, March 1953. Price 15¢.

   THE WORKSHOP REPORT ON COMMUNITY ORGANIZATION. Price 50¢.

   THE EMOTIONAL ELEMENT IN LEARNING IN PROFESSIONAL EDUCATION FOR SOCIAL WORK by Charlotte Towle. Price 50¢.

Margaret Creech, chairman of the Commission on Program, Planning and Services, and Publications, has announced the appointment of Frank Hertel, Associate General Director, Community Service Society of New York, as chairman of the newly reconstituted Recruitment Committee of the Council. Dean Harleigh B. Trecker of the University of Connecticut served as chairman of the Council's first Committee on Recruitment.

Publications received:

1. GROUP DYNAMICS: RESEARCH AND THEORY by Darwin Cartwright and Alvin Zander; Row, Peterson and Company, Evanston, Illinois, 1953. Price $6.

2. EDUCATION FOR PUBLIC WELFARE ADMINISTRATION by Harold Kenneth Fitzgerald, M.S.S.W., The Catholic University of America, Studies in Social Work, Abstract Series, Vol. I 1952, Washington, D. C. Price 50¢.